

Parent/Guardian Medication Permission and Authorization

I hereby acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so, or in the event of a medical emergency. I hereby authorize the School Principal or his/her designee, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer in accordance with School Medical Procedures), lawfully prescribed medication and non-prescribed medication in the manner described in the Physician's Order. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual who does not have medical training, and I specifically consent to such practices.

I understand that this authorization is not effective unless the School Principal or his/her designee has approved the medication authorization for my child and signed this form in the space provided below.

I further acknowledge and agree that, when such medication is to be administered or attempted to be administered, I waive any claims I might have against the School, the Catholic Bishop of Chicago, the parish, or any of their employees or agents, wither jointly or severally, from and against any and all claims, damages, causes of action, or injuries incurred or resulting from the administration or attempted administration of said medication.

Parent/Guardian Signature

Date Signed

Parent/Guardian Name

Address, City, State, and Zip

Home Telephone

Business or Mobile Telephone

Medication Authorization Approved this ____ day of _____, 200__.

School Representative's Signature

On behalf of St. Joseph School, Wilmette, Illinois.

Medication Authorization Form
St. Joseph School, Wilmette, Illinois

Student Name(last, middle, first) Date of Birth Grade Date

Medications may be administered in school in accordance with the School Medication Procedures. No medication may be administered in school unless both the students' physician and parent/guardian have completed, signed, and returned the following to the school Principal or his/her designee:

- Medical Authorization Form
- Unsupervised Self-Administration Request Form (if the student intends to carry and use medication on his/her own during school hours or during school activities)
- Prescription Medication in the original labeled container as dispensed or non-prescription medication in the manufacturer's labeled container. The medication label shall contain the student's name, name of medication, direction for use and date.

Physician's Order

Medication/health care treatment Dosage Time(s) to be administered

Intended effect of this medication

Expected side effects, if any

Other medications the student is taking

May student self-administer medication under supervision of school personnel who do not have medical training?

Please circle YES NO

Administration Instructions

Please circle: Discontinue Re-evaluation Follow-up _____
Date

Physician's /Prescriber's Signature Date signed

Physician's /Prescriber's Name Emergency Telephone Number

Address, City, State, Zip